VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

March 15, 2016

Ms. Beth Peer, Manager
Our House Too Residential Care Home
69 1/2 Allen Street
Rutland, VT 05701-4501

Dear Ms. Peer:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 3, 2016.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PRINTED: 02/16/2016
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0377	A. BUILDING: _____ B. WING _____	C 02/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE TOO RESIDENTIAL CARE HOME	69 1/2 ALLEN STREET RUTLAND, VT 05701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site re-licensure survey was conducted by the Division of Licensing and Protection in conjunction with two entity reports and an anonymous complaint between the dates of 2/2/16 -2/3/16. There were regulatory findings with both the survey and the complaint investigations. The findings are as follows:	R100		
R136 SS=A	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on record review and confirmed by staff interview the facility failed to reassess 1 of 10 sampled residents (Resident #2), annually or at any point in which there is a change in the resident's physical or mental condition. The findings include the following: Per record review on 2/2/16, Resident #2 was admitted to Our House Too, on 1/8/15. State assessment form identifies that the assessment was completed and signed by the Registered Nurse (RN) on 1/20/15. Per interview with the RN on 2/2/16 at approximately 4:45 PM, the resident has not had an annual review assessment as of today. Therefore, the annual assessment is 13 days	R136	R136 Resident assessment was overdue, since surveyors Findings, the annual assessment has been completed - all assessments are to be kept Current - RN is aware of expectations and will be more diligent. House mgr will monitor. assessment due dates will be reviewed at the first Tuesday of each month at the monthly managers meeting, Nurses will be advised of any shortcomings to be Corrected immediately	2/4/16

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Kelly Pass — Manager — 3/9/16

STATE FORM 8899 P9JV11 If continuation sheet 1 of 26

Paula Zabit — Administrator — 3/9/16

R136 - R999 POC's accepted 3/15/16 BBartell RN | PME

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R136	Continued From page 1 over due.	R136		
R142 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.8 Level of Care and Nursing Services 5.9.b The following services are not permitted in a residential care home except under a variance granted by the licensing agency: intravenous therapy; ventilators or respirators; daily catheter irrigation; feeding tubes; care of stage III or IV decubitus; suctioning; sterile dressings. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to obtain a variance for 1 of 6 residents reviewed in the survey sample, Resident # 7. Findings include: During observation on day one of the survey, Resident #7 was receiving feedings through a feeding tube, placed in the abdomen. The medical record did not provide evidence that a variance has been obtained, but the House Manager was sure there was one. A call was placed to the State Agent at 4:20 PM and they reported there was no evidence that a variance had been given. On 2/3/16 at approximately 9:30 AM, the senior manager stated that the owner/administrator would have that information and s/he did not know the whereabouts of the variance and the owner/administrator would not be available until next week. Further interview with the house manager at 4:30 PM, s/he was unable to locate a variance for care for Resident #7.	R142	R142 Variance request from 2008 when pre-approved LOC variances were in effect was provided after survey - New LOC variance request is in process - Administrator to monitor for compliance. Variances will be reviewed at the first monthly Manager meeting - Need for new variances will be identified and requested immediately when necessary - Administrator will monitor for Compliance.	3/21/16

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R155	Continued From page 2	R155		
R155 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c. (12) Assume responsibility for staff performance in the administration of or assistance with resident medication in accordance with the home's policies. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the nurse failed to ensure that the administering of medication was done in accordance with the home's policies for 5 of 9 residents observed, Residents #4, 7, 8, 9 & 11. Findings include: 1.) Per observation, Resident #4 was administered enteric coated Ferrous Sulfate 325 milligrams by mouth on 2/2/16 at 5:25 PM. The medication delegated staff member crushed the Ferrous Sulfate and placed it in applesauce and administered it to Resident #4. The staff member confirmed immediately after the administration, that the Ferrous Sulfate had been crushed, s/he stated that they did not know that it couldn't be crushed because it was not indicated on the packet that came from the pharmacy. The Registered Nurse (RN) stated at the time of discovery, that the packet did not indicate not to be crushed, but confirmed that enteric Ferrous Sulfate should not be crushed. 2.) Per observation, Resident #7 was administered Levaquin Solution at 4:30 PM on 2/2/16. The order is for Levaquin 750 mg (milligrams) and the label reads 25 mg/ml (milliliter) and to give 30 ml. The medication	R155 R155	All of these bullets have been reviewed with the RN and the manager to assure an appropriate Plan to Correct – • Checking orders from the pharmacy – • Communicating with Doctors to assure realistic orders • Testing, observing and educating med certified staff Frequently will force staffs awareness of expectations – RN and manager will monitor for accuracy and Compliance – New weekly skills Competency check is being developed for RN and manager – RN will monitor results with manager –	3/2/16 4/1/16

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R155	Continued From page 3 delegated staff member prepared and administered only 10 ml via feeding tube. After administration the label and order was reviewed with the staff member and s/he confirmed that only 10 ml instead of the ordered 30 ml was given and s/he then prepared and administered the remaining dose of 20 ml. Reviewed with the RN at this time and s/he stated that the staff member needs to read the label closer. 3.) Per observation, Resident # 9 was administered Acetaminophen topically on 2/2/16 at 12:15 PM, the medication delegated staff member applied two squirts from the pump bottle into his/her gloved hands and applied it to the chest of the resident. After administration the staff member was asked when the medication expired and s/he stated that they did not know because there is nothing on the label to indicate expiration. The order and the label on the bottle state that the dose is 325 mg/2 ml. The staff member was asked how they knew that two squirts was equivalent to 2 ml and s/he stated that s/he does not know if that is how much is in the two squirts, but that was the way they were taught to apply. The RN was not able to ensure that two squirts are equivalent to 2 ml at 4:30 PM. The RN also confirmed at this time that there is no expiration date on the label and stated that the staff should be picking up on that. 4.) Resident #7 has an order to administer 100 ml of water every hour, dated 1/31/16, obtained via a telephone order. Review of the Medical Administration Record (MAR) for February does not have signatures for the night shift administering the water flushes. During day one of the survey, one or more surveyors were near the entrance to Resident #7's room between the hours of 10 AM and 4:30 PM. The only	R155	New medications received will be added to MAR by RN - manager will review for accuracy - Weekly training/testing will be conducted for random staff Competency - results will be reviewed with manager and RN - Necessary actions will be taken immediately. RN and manager will monitor skills and training.	2/4/16 4/1/16

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R155	Continued From page 4 administration of water for the resident was during medication administration and to flush the feeding tube after Jevity feeding. The staff member that was responsible for administering the flushes on the day shift had signed the MAR to indicate the flushes were done. The RN stated that they were ordered every hour because the resident had a temperature. 5.) During the observed tube feedings for Resident #7 on 2/2/16 at 11:00 AM, the staff member did not check for placement of the feeding tube per training and policy. S/he did not aspirate for residual prior to administration of feeding. Confirmation made by the staff member at 11:47 AM that placement had not been checked. Again on 2/2/16 at 4:25 PM, the evening staff member responsible for the tube feeding was observed not to check tube for placement and did not check residual prior to administration of feeding. Confirmation made by staff at this time. 6.) On 2/2/16 at 2:00 PM the medication delegated staff member prepared Risperidone 0.125 milligrams for Resident #11. The resident was not alert and did not accept the medication when it was offered. The medication delegate then placed the medicine cup with the medication in it into the medicine closet in the residents designated box. At the change of shift the on coming staff responsible for medication administration was alerted that Resident #11 had refused the medication and that it was in the medicine closet. At 3:10 PM the staff member placed a call to the Registered Nurse to let him/her know that it had not been given at 2:00 and asked if it could be given at this time. When s/he received the approval to give the medicine, s/he retrieved the Risperidone that	R155		

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R155	Continued From page 5 was prepared by the day shift caregiver from the closet and then crushed it and administered it to Resident #11. At 3:20 PM s/he confirmed that s/he had given the medication prepared by the other caregiver. Per interview with the RN at 4:30 PM, s/he stated that the staff are not to give anything that was prepared by anyone else and s/he was not made aware at the time of the call that the medication had been prepared by the day shift. 7.) On 2/3/16 at 8:00 AM, the medication delegated staff member administered Lasix 40 mg by mouth to Resident #8. Review of the medical record presents that the physician orders, dated 1/5/16 states that resident is to have Lasix 40 mg one tablet oral daily in AM (morning) as needed for swelling. Orders and MAR reviewed with the house manager at 3:10 PM and s/he confirmed that the orders in the chart and the MAR do not match and that the order is to give as needed and the MAR is to give every day. S/he said that they would have the RN check the orders. The RN stated that the resident has been receiving Lasix every day for a long time, but confirmed that the orders are to be given only as needed. S/he stated that they are responsible for checking the MAR and physician orders.	R155		
R161 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.b The manager of the home is responsible for ensuring that all medications are handled according to the home's policies and that designated staff are fully trained in the policies	R161		

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R161	Continued From page 6 and procedures. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the manager of the facility failed to ensure that all medications are handled according to the home's policies for 2 of 9 residents, Resident # 7 and 11. Findings include: 1.) Resident #7 has an order to administer 100 ml of water every hour, dated 1/31/16 and obtained via a telephone order. Review of the Medical Administration Record (MAR) for February does not have signatures for the night shift administering the water flushes. During day one of the survey, one or more surveyors were near the entrance to Resident #7's room between the hours of 10 AM and 4:30 PM. The only administration of water for the resident was during medication administration and to flush the feeding tube after Jevity feeding. 2.) During the observed tube feedings for Resident #7 on 2/2/16 at 11:00 AM, the staff member did not check for placement of the feeding tube per training and policy. S/he did not aspirate for residual. Confirmation made by the staff member at 11:47 AM. On 2/2/16 at 4:25 PM, the staff member responsible for the tube feeding was observed not to check tube for placement and did not check residual. Confirmation made by staff at this time. Interview with the house manager at 4:30 PM after s/he was notified of the finding, stated that the staff knows they are suppose to check the placement of the feeding tube before they administer anything via the tube. S/he further stated that they have all been taught.	R161	R161 Weekly skills check will identify staff who are not following instructions/procedures- Outcome of each will determine what training is to follow or that they are suspended from med passes at least temporarily. Manager and RN will monitor for completion and create action plan on a case by case basis.	4/1/16

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R161	Continued From page 7 3.) On 2/2/16 at 2:00 PM the medication delegated staff member prepared Risperidone 0.125 milligrams for Resident #11. The resident was not alert and did not accept the medication when it was offered. The medication delegate then placed the medicine cup with the medication in it into the medicine closet. At the change of shift the on coming staff responsible for medication administration was alerted that Resident #11 had refused the medication and that it was in the medicine closet. At 3:10 PM the staff member placed a call to the Registered Nurse to let him/her know that it had not been given at 2:00 and asked if it could be given at this time. When s/he received the approval to give the medicine, s/he retrieved the Risperidone that was prepared by the day shift caregiver from the closet and then crushed it and administered it to Resident #11. Policy review presents that medications are not to be administered by anyone but the person that prepares them. At 3:20 PM s/he confirmed that s/he had given the medication prepared by the other caregiver. Per interview with the RN at 4:30 PM, s/he stated that the staff are not to give anything that was prepared by anyone else.	R161		
R163 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (1) A registered nurse must conduct an assessment consistent with the physician's	R163		

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R163	Continued From page 8 diagnosis and orders of the resident's care needs as required in section 5.7.c This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that the registered nurse conducts an assessment consistent with the physician's orders for 2 of 9 residents reviewed, Resident #5 and 8. Findings include: 1.) On 2/2/16 at 5:25 PM, during medication administration, the delegated staff asked which dose of Warfarin should Resident # 8 be getting because there were two of them. One order on the Medication Administration Record (MAR) read to give Warfarin 2.5 milligrams (mg) daily at 5:00 PM and the one listed right above that said to give Warfarin 2 mg. The physician order in the medical record stated to give the Warfarin 2 mg daily. At 4:55 PM the Registered Nurse (RN) stated that s/he does the medication training and s/he reviews the MAR each month. S/he stated that s/he checks the MAR against the one from the month before doesn't check them against the medical record. S/he said that s/he reviews all the orders so knows if there is anything new and must have missed this one, but confirms that the house manager will sometimes take orders. 2.) On 2/3/16 at 8:00 AM, the medication delegated staff member administered Lasix 40 mg by mouth to Resident #8. Review of the medical record presents that the physician orders, dated 1/5/16 states that resident is to have Lasix 40 mg one tablet oral daily in AM (morning) as needed for swelling. Orders and MAR reviewed with the house manager at 3:10 PM and s/he confirmed that the orders in the chart and the MAR do not match and that the	R163 R163	All Systems check has been reviewed with RN, manager and Caregivers - All Changes have been made for accuracy - RN monthly Audit Procedure change will assist in identifying errors. RN daily review of Changes as needed expected. House manager will monitor.	2/16/16

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R163	Continued From page 9	R163		

order is to give as needed and the MAR is to give every day. S/he said that they would have the RN check the orders. During interview at 4:10 PM, the RN stated that the resident has been receiving Lasix every day for a long time, but confirmed that the orders are to be given only as needed. S/he stated that s/he is responsible for checking the MAR and physician orders.

3.) During medical review on 2/3/26, Resident #8 has an order for Colchicine 0.6 mg by mouth daily as needed for gout flare-ups, listed on the MAR and medication list. Review of the last signed physician orders dated 1/15/16, there is no order for Colchicine. Per interview with the house manager at 3:10 PM, the resident was taken to the doctor and a list of the medications was taken with him/her. S/he said that the RN reviews the medications after a doctor visit. At 4:10 PM, the RN confirmed that she reviews the medications and did not realize the medication was not on the recent signed orders.

4.) On 2/3/16 medical review for Resident #5 presents that s/he was admitted to the facility 11/7/15 with diagnosis that includes Coronary Artery Disease, Arteriosclerotic Coronary Vascular Disease and Pacemaker placement. His/her physician orders represent that s/he is to have Toprol XL 100 mg tablet (1/2 tablet) to equal 50 mg by mouth daily. Review of the MAR does not represent that the resident is to take the Toprol XL. Reviewed with the house manager at 3:10 PM and s/he confirmed that the admission orders included that the Toprol XL was part of the orders. Per interview with the RN at 4:10 PM, confirmed that s/he had spoke with the Physician Assistant upon admission to review the medications and was told that the resident needed to be on the Toprol because of his

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R163	Continued From page 10 coronary diseases. S/he confirmed that s/he did not question the Toprol not being carried over from November to December. S/he stated that s/he reviews and prepares the MARs each month, but s/he will often take them home and goes from MAR and does not review the orders with the medical record.	R163		
R165 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (3) The registered nurse must accept responsibility for the proper administration of medications, and is responsible for: i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects; ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications; iii. Assessing the resident's condition and the need for any changes in medications; and Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that the Registered Nurse (RN) is responsible for teaching, monitoring and	R165 R165	Weekly skills/training for med Certified staff will be implemented and Conducted by an RN - Outcomes will be discussed at weekly managers meeting manager will monitor -	3/17/16

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R165	Continued From page 11 evaluating designated staff performance In carrying out the nurse's instructions fro medication administration. Findings include: Per interview with house manager on 2/3/16 at 10:00 AM, s/he stated that s/he trains the caregivers that will be delegated to pass medications. S/he said that s/he first gives them a test to take, she has them review the policy/procedure to look up answers for the test and then the that is corrected by the RN, followed by a medication pass while the caregiver shadowing another delegated medication staff member. S/he further stated that the RN does not do much of the training until it is time for them to be certified. When the manager feels the staff member is competent, s/he sets up the time for the staff member to shadow and then sets up a time for the RN to come in to watch a medication pass and then the RN will deem them as certified. S/he further stated that the RN doesn't re-evaluate or monitor the day shift because s/he is there to answer questions and the RN evaluates and monitors the evening shift. The house manager also stated at this time that s/he does the training for staff that will be doing tube feedings. S/he said that she will show them the Medication Administration Record, where the equipment and Jevity is kept, how to clean and check for residual by aspirating before giving medications or the Jevity. The RN will then check for competency during medication certification. At 12 noon per RN interview, s/he says that the medication training consists of giving the handbook to study the house manager goes through the book with them. S/he said that she will correct the test after they take it and then they shadow the house manager or whoever s/he	R165		

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R165	Continued From page 12 delegates and then the RN will do a medication pass with them. S/he said that the tube feedings are done by other than him/her and before they do it alone, s/he will be with them and then sign off to certify.	R165		
R166 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (4) All medications must be administered by the person who prepared the doses unless the nurse responsible for delegation approves of an alternative method of preparation and administration of the medications. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to insure that all medications administered by the person who prepared the doses unless the nurse responsible for delegation approves of an alternative method of preparation and administration of the medications. On 2/2/16 at 2:00 PM the medication delegated staff member prepared Risperidone 0.125 milligrams for Resident #11. The resident was not alert and did not accept the medication when it was offered. The medication delegate then placed the medicine cup with the medication in it into the medicine closet. At the change of shift the on coming staff responsible for medication administration was alerted that Resident #11 had	R166 R166	Communication! The Caregiver knew this was an error - weekly skills/training will benefit all staff in order to eliminate this kind of decision making. RN and House manager will monitor.	2/3/16

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R166	Continued From page 13 refused the medication and that it was in the medicine closet. At 3:10 PM the staff member placed a call to the Registered Nurse to let him/her know that it had not been given at 2:00 and asked if it could be given at this time. When s/he received the approval to give the medicine, s/he retrieved the Risperidone that was prepared by the day shift caregiver from the closet and then crushed it and administered it to Resident #11. At 3:20 PM s/he confirmed that s/he had given the medication prepared by the other caregiver.	R166		
R179 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne	R179		

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R179	Continued From page 14 pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on employee file review and staff interview the facility failed to ensure that 2 of 8 employees receive twelve (12) hours of training each year for each staff person providing direct care to residents. The findings include the following: Review of employee files on 2/3/16 presents that two caregivers did not have the required twelve hours of training. Two caregivers did not have training hours in Emergency response, Resident Rights, Abuse/Neglect and Exploitation and one did not have training hours for Infection Control. This was confirmed by the Human Resource Registered Nurse on 2/3/16 at 1:05 PM.	R179 R179	IN-Services and Indep. trainings are always mandatory - They will be more closely Supervised for Compliance - Staff who miss any mandatory meeting will be offered an alternative training but must complete Such within 5 days or will be removed from the schedule until they comply. HR RN will monitor For maintenance.	3/17/16
R187 SS=A	V. RESIDENT CARE AND HOME SERVICES 5.12.b. (1) A resident register including all discharges, transfers out of the home and admissions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to have a resident register that includes all discharges, transfers out of the home and admissions. Findings include: Upon request for the resident register, the house manager presented a current list of the census. Further review of previous logs presented as	R187 R187	The original resident register was destroyed during Construction - Since Survey has been recreated and will be maintained by the house manager. RR will be reviewed Once monthly at weekly managers meeting with Administrator to monitor for Compliance and accuracy.	2/16/16

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R187	Continued From page 15 incomplete. Confirmation by the house manager on 2/2/16 at 11:35 AM that the register does not include discharges of residents and that there are residents listed that no longer resident at the facility.	R187		
R213 SS=E	VI. RESIDENTS' RIGHTS 6.1 Every resident shall be treated with consideration, respect and full recognition of the resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to treat each resident with respect and dignity, Residents # 6, 7, 9 and 10. Findings include: 1.) Resident # 9 was administered Acetaminophen topically on 2/2/16 at 12:15 PM, the medication delegated staff member applied two squirts from the pump bottle into his/her gloved hands and applied it to the chest of the resident while the resident was seated at the dining room table waiting for lunch. The resident had a visitor and there were other residents in the dining room. After the administration the staff member confirmed that the resident was in a public area at the time of administration and it probably should have been done somewhere else. 2.) On 2/2/16 at 4:45 PM, Resident #10 was wandering in the facility with pajamas on and then was later seen sitting at the dining room table. At	R213 R213	Trainer has been advised of poor execution from staff with survey findings - she and the manager have met with these Caregivers individually to review actions, train/retrain each appropriately. However this is a special Care unit for people with dementia - Familys have hours of informational education on our individual caregiving - Early washups may be necessary for Comfort for Certain individuals and families are aware and support these decisions - unconventional eating isn't uncommon - But all should be done with dignity - i.e. - PJ's Covered with a Robe or sweater. Staff has been advised that any	

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R213	Continued From page 16 5:05 PM Resident # 6 was also seen sitting at the dining room table in pajamas. Interview with staff at this time presented that the one resident had been incontinent and the other had a shower and s/he is sometimes resistive after dinner, so it was not unusual to put them in pajamas because it is easier. 3.) On 2/2/16, during a tube feeding observation of for Resident # 7 at 4:00 PM, the resident began to cough and had mucous in his/her mouth. The caregiver used the hem of the resident's shirt to scoop the mucous out of Resident #7's mouth. When the tube feeding was completed, the caregiver left the room. S/he confirmed at 4:10 PM that she had used the shirt to wipe the mucous out of the mouth. 4.) On 2/2/16, during the evening meal observation at 5:45 PM, Resident #10 had been eating a sandwich and half of the sandwich had fallen on the floor and half of the other half was on her chair, s/he had also spilled some of his/her drink and had dumped some of his/her pears onto the plate and was trying to bite the bowl. The caregiver stated that they don't assist him/her because they get angry and then won't eat, but did confirm that his/her appearance at this meal was not dignified. 5.) Per observation on 2/2/16 and 2/3/16, the facility uses large cloth incontinent pads on the couches and chairs. Per house manager, they are used to protect the furniture when the residents are incontinent. On 2/3/16 at 5:45 PM s/he confirmed that it could be a dignity issue for the residents.	R213 Cont'd	Resident who will only "eat on the go" Should be Served Small amounts at one time monitoring closely to Keep momentum going on an individual basis - Trainer and House manager will monitor per resident - Needs are expected to be on the Careplan and Staff trained accordingly - Purchaser has been reminded that cloth soakers should Not be white but more color coordinated with furniture - White pads are intended for resident beds - Trainer and manager will monitor. • Paragraph 3 was sloppy Caregiving at best - Caregiver has been reminded of the importance of her job and decision making.	2/10/16

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R224	Continued From page 17	R224		
R224 SS=G	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that 2 of 8 residents sampled, Resident #3 and #6 were free from sexual and physical abuse and neglect. The findings include the following: 1.) Per observation on 2/3/16, at 10:28 AM, Resident # 6 had wandered into the bedroom of Resident #2. Resident #2 was kissing Resident #6 and they were both touching each other inappropriately. The house manager was notified at the time of observation and s/he redirected Resident #6 from the bedroom. Per interview with the manager at this time, the residents have dementia and the families have not consented to the behavior. At 10:45 AM per interview with a caregiver that was in the vicinity at the time that Resident #6 had wandered into the room stated that s/he didn't think anything about where the resident wandered to because a lot of the residents wander into Resident #2's room. S/he said that the two will hug and hold hands, but nothing has ever happened before. Resident #2 had been observed at different times, during the survey, directing his/her attention toward another resident. Resident #2 was also involved in a prior incident that involved pushing another resident because both of them were interested in another resident of the opposite sex. Per interview with the house manager at 2:15 PM, she confirmed	R224	R224 All residents have dementia - Staff is trained to monitor actions - families are part of on going communication as situations arise. Actions are taken as deemed necessary - Each residents whereabouts is to be closely monitored at all times. Staff is trained to report any inappropriate findings immediately - Action plans are established on a case by case basis. 2) Not every action can be predicted thus the value of our video surveillance system - the Caregiver who was abandoned by her Co worker did everything right - once evidenced - Police were called, APS + SC reports were filed - Caregiver is being prosecuted by the VT State Attorney General. Another Caregiver was onsite within 30 minutes.	2/17/16

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R224	Continued From page 18 that the residents not been monitored for behaviors of the type witnessed, but they have hugged and held hands before and Resident #6 has been in the room of Resident #2 before, also confirmed that the behavior was inappropriate. 2.) Per review of intake information dated 1/15/16, provided by the facility administrator, Resident #3 was observed on a video surveillance tape dated 12/31/15 at 1:58:58 through 2:00:10, being pushed by resident care attendant #1, from behind causing the resident to fall to the floor. The employee walked away from Resident #3 who was lying on the floor. The attendant did not offer the resident assistance nor did s/he report the occurrence to resident care attendant #2, who was on duty at the time. Per intake information the perpetrator abandoned her/his position at approximately 3 AM, leaving the facility understaffed and without a medication technician. Per observation of the video surveillance on 2/3/16 at approximately 9 AM, in the administration office for the four "Our House" facilities, with the administrative staff and the manager of the facility, confirmation is made that the surveillance tape evidences the physical abuse to Resident #3 by employee #1. Per resident care service note dated 12/31/15, the resident returned to the facility after Emergency Room evaluation with a diagnosis of right hip contusion and treatment advised.	R224 Cont'd	Continue monitoring resident actions 24/7 and Create action plans where necessary - Continue educating staff on responsibility of assuring all residents are safe. RN, Manager, All staff And administrator will monitor for Compliance. Prior to admission all prospective Families meet with the administrator dementia is discussed in detail - People with dementia living in a Community Can develop Friendships, though untraditional, they still Create bonds - People with dementia normally need Comfort, Kind words, Soft touch, Care and Compassion. This is expected and effective in Creating a happy, healthy environment For our residents and their Families - all Families are encouraged to Communicate with the administrator 24/7.	2/29/16
R228 SS=A	VI. RESIDENTS' RIGHTS 6.16 Residents have the right to formulate	R228		

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R228	Continued From page 19 advance directives as provided by state law and to have the home follow the residents' wishes This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure that 1 of 10 residents sampled, formulated advanced directives as provided by state law and to have the home follow the residents' wishes. The findings include the following: Per record review on 2/2/16 Resident #2 was admitted to Our House Too, on 1/7/15. Document titled "Telephone Order Form" signed by the physician on 6/15/15, identifies orders as follows: Do Not Resuscitate (DNR) unless changed by me. Clinician Orders for Life Sustaining Treatment (COLST) form in progress. Physician progress note dated 8/31/15 paragraph titled: "Impression" (Imp.) #5 evidences COLST in progress with family for DNR/DNI (Do Not Intubate). {"I called family in Pennsylvania and we are in contact COLST mailed to him"}. Per interview with the Residential Care Home Manger on 2/2/16 confirmation was made that the facility has not received any COLST form from the family or the physician.	R228 R228	All residents have legal reps - Some are family with many members - NOT all will agree on advance directives though we Continue to encourage We Cannot insist - House manager will follow up and document attempts/conversations in the residents chART - Physician will be advised of status and/or changes. manager will monitor. All charts have been reviewed for Advance directives, managers log will maintain status, changes and conversations of such in detail - detail will be logged in the resident chART - manager will monitor.	2/3/16 2/16/16
R247 SS=E	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or	R247		

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R247	Continued From page 20 heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to label and date all perishable food. Findings include: 1.) Accompanied by a caregiver on 2/2/16 for the initial tour, it was observed at 10:53 AM that refrigerator #2 in the kitchen, had two jars of grape jelly, a jar of applesauce, a container of stuffed shells (per the caregiver), lettuce, a bottle of barbecue sauce and a package of shredded cheese. None of these items were dated as to when they were opened. The shells and the shredded cheese were not labeled as to what the contents were in the packages. In the freezer there was a package of chicken nuggets that did not have a label as to what the contents were and no date as to when opened. These were confirmed at the time of discovery by the caregiver. 2. In one of the kitchen cupboards there were open jars of peanut butter and a container of Fluff that were not dated as to when they were open. In a food storage base cupboard there was an open bag of cereal and and open macaroni, also without dates as to when opened. These discoveries were confirmed by the caregiver at the time of discovery.	R247	R247 Staff has been reminded of the need to label/date Open Foods - Mandatory in-service on 3/16 will discuss in detail Surveyor Findings as labeling items in original containers with expiration dates has NOT been practiced in the past - (4/14/15 POC ON FILE) all staff responsible for Compliance, manager will monitor	2/4/16 3/16/16
R253 SS=D	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.c All food service equipment shall be kept	R253		

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R253	Continued From page 21 clean and maintained according to manufacturer's guidelines This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that all food service equipment was kept clean. Findings include: During the initial tour of the facility on 2/2/16 at 10:55 AM, accompanied by caregiver, in the kitchen the microwave turntable had dried peas and matter and there was build-up on the sides and top of the inside of the microwave. The caregiver stated at this time that it should have been cleaned and confirmed that there was food build up in the microwave.	R253	R253 This is just Careless - Staff has been reminded that all messes should be cleaned at the time it occurs - also will be discussed at 3/16 in-service - manager will monitor	2/4/16
R259 SS=D	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.i Poisonous compounds (such as cleaning products and insecticides) shall be labeled for easy identification and shall not be stored in the food storage area unless they are stored in a separate, locked compartment within the food storage area. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store poisonous compounds in a locked compartment in the food storage area. Findings include: During the initial tour on 2/2/16, accompanied by a caregiver, at 10:53 AM, in the kitchen, there	R259	R259 Items have been secured. Locked boxes have been ordered for any products in the kitchen - staff has been reminded of regulations - also will be discussed at 3/16 in-service - manager will monitor	2/4/16

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R259	Continued From page 22 were eight cans of disinfectant spray, three cans of aerosol oven cleaner, two cans of aerosol furniture polish and 3 containers of Cascade dishwasher detergent. The manager of Our House Outback, who was at the facility to assist with the survey, confirmed that the chemicals were inappropriately stored at the time of discovery.	R259		
R266 SS=D	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the home failed to provide and maintain a safe, functional, sanitary, homelike and comfortable environment. Resident #7 regarding infection control and homelike environment for all residents. Findings include: 1.) Per observation on 2/2/16 and 2/3/16, the facility uses large cloth incontinent pads on the couches and chairs. Per house manager, they are used to protect the furniture when the residents are incontinent. On 2/3/16 at 5:45 PM s/he confirmed that it did not a homelike environment for the residents. 2.) During initial tour of facility, accompanied by caregiver on 2/2/16 at 10:50 AM, Resident #7 had a suction machine at the bedside. Resident #7 requires oral suctioning as needed, there was	R266	R266 1) All families are aware of the use of Soaker pads on furniture, NOT only for incontinence but also for Spills - white Soakers were purchased to be used on resident beds - "designer" Soaker pads are in the house and more have been ordered - staff has been reminded of proper use - Review to be done at in-service on 3/16. All staff responsible - manager to monitor 2) Responsible staff was questioned and reprimanded - all Staff Knows proper usage	2/10/16 3/16/16

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0377	A. BUILDING: _____ B. WING _____	C 02/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE TOO RESIDENTIAL CARE HOME	69 1/2 ALLEN STREET RUTLAND, VT 05701

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R266	Continued From page 23 thick yellow mucous in the tubing as well as the Yankaur Suction oral apparatus. Per the caregiver, the resident probably needed to be suctioned during the night and the tubing is suppose to be cleansed with water after each use. S/he also confirmed at this time that the tubing and oral piece had not been cleansed.	R266	including cleaning - review and retraining completed by manager-	
R272 SS=D	IX. PHYSICAL PLANT 9.2 Residents' Rooms 9.2.e Resident bedrooms shall be used only as the personal sleeping and living quarters of the residents assigned to them. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to insure that resident's bedrooms be used only as the personal sleeping and living quarters of the residents assigned to them for 1 of 13 residents, Resident # 5. Findings include: During a tour of the facility on 2/2/16 at 10:30 AM accompanied by a caregiver, it was observed that Resident #5 had two closets in their room. Upon inspection, one of the closets contained a vacuum cleaner, storage boxes for things returned to the pharmacy, some linen and blankets and other items. The caregiver stated that the closet was used for storage for the facility. S/he confirmed at this time that staff have to go in and out of Resident #5's bedroom in order to get things from the closet and that the resident can't store any of their belongings in that closet.	R272 R272	Also submitted after Survey was a letter dated 3/31/03 in which it states that "two physical plant variances" were given at the time of original license - one of the two has been rectified years ago - this one remains - There have always been two very large closets in the room and every occupants family has been made aware of it's use - Items in this closet need only be accessed when the resident would normally be out of the room. I would ask that this be understood as ongoing, as space is limited.	

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OUR HOUSE TOO RESIDENTIAL CARE HOME	69 1/2 ALLEN STREET RUTLAND, VT 05701

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R302	Continued From page 24	R302	Accessing the closet from outside of the room has been explored but a heating pipe is an obstacle as well as it being accessed in the outside hallway.	
R302 SS=B	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to conduct fire drills on a quarterly basis. Findings include: During review of facility conducted fire drills on 2/2/16, the last conducted fire drill was 6/24/15. Interview with the house manager at 11:35 AM, s/he stated that s/he thought they had to do six per year and after reviewing the State Regulations for Residential Care Homes, s/he confirmed that s/he had not completed the fire drills quarterly.	R302 R302	Staff has a schedule every year for fire drills- this is an unacceptable oversight - Fire drill schedules will be reviewed monthly at a weekly managers meeting and have been added to the managers daily handbook - Six Fire drills are scheduled and must be conducted for Compliance with DLP and Fire Safety Codes - manager will monitor.	2/4/16
R999 SS=C	MISCELLANEOUS Based on observation and staff interview, the facility failed to encourage or provide activities for the Enhanced Residential care residents.	R999		

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R999	Continued From page 25 Findings include: It was observed on 2/2/16 that most of the residents were seated in chairs in the sitting area and a television was turned on to music videos. Others were sitting at the tables in the dining room and a couple were walking about the facility. At 2:00 PM, a staff member was asked about the type of activities the residents do, s/he said that they had not been done today and there aren't very many activities for the residents. Another staff member responded that there are no activities for the residents. S/he said that they do them if they have time, but not every day, usually they are too busy. Staff member that is responsible for education regarding care stated that they have a scheduled activity book, but s/he can not locate it. S/he said that they try to do something every day, but sometimes it gets too busy. The evening medication staff stated that there are no activities because they are too busy, but the residents like to color and they will try to let them color whenever they can. Resource: Vermont Department of Disabilities, Aging and Independent Living Choices for Care, Lon-Term Care Medicaid Program Manual, Page IV.8.-2, #4 Recreational Activities.	R999	R999 Activities are expected each day on at least two shifts - 3/16/16 Trainer has reviewed the definition and expectations with staff interviewed - and will be discussed at 3/16 in-service. 2/4/16 Trainer and manager will monitor for compliance -	